The Hub Dental Practice

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Dr David Gilmartin, Dr Jaime De Castro Torres, Dr Monica Cueva Moya, Dr Alvaro De Castro Torres, Dr Gulelala Azhar, Dr Chivani Tailor Dr Maria Ruiz Del Barrio, Dr Kamilah Makda, Dr Elisabet Cortes, Dentist, Dr Ana Patricia Senra Basto Dental Surgeon. Dr Iyad Abou-Rabii PLT Oral Surgery, Dr Giovanni Antonio Marras PLT Periodontics, Dr Konstantinos Tzamalas, Specialist Orthodontist, Dr Aaron Lopez, Specialist Periodontist. Mrs Nur Gilmartin, Dental Hygienist. Dr Etienne Deysel, Sedationist. Miss Sam Singleton, Practice Manager

Title: **Forename:** **Surname:** **Date of birth:** // // **Sex:**

Address:

Tel no: (Home): **(Work):** **(Mobile):**

Email Address (Personal): **Email address (Work):**

How long since received dental treatment: **Occupation:**

Your Doctors Name & Address:

Name of any Dental Insurance you have:

Medical Questions	Yes/No	If yes please give details below.
Are you a smoker? (Smoking can seriously affect the success of dental treatment and dental health). If Yes how many a day?		
Are you attending or receiving treatment from a doctor, hospital, clinic, or specialist?		
Are you taking any medicines? (Tablets, creams, ointments, injections, inhalers or others)?		
Are you pregnant if yes give projected birth date?		
Are you taking or have you taken steroids (in any form) in the last five years?		
Have you or ever had cancer or are you taking or have you ever taken Bisphosphonates or any other drug related to cancer treatment?		
Are you allergic to any medicines, food, materials or suffer from any hay fever, eczema or any other allergy?		
Have you had rheumatic fever or chorea (St Vitus dance) or history of Infective Endocarditis?		
Have you had any history of any kind of Hepatitis, had jaundice, Liver disease, Kidney disease, Thyroid disease, had a joint replacement or carry a warning card (Heart, kidney, joint)?		
Have you had any blood tests, inoculations, etc in the last 2 years?		
Have you or any of your family been treated with growth hormone or any of your family resided with any one with NV CJD or TB?		
Have you ever had your blood refused by the blood transfusion service and if yes what was the reason?		
Have you been hospitalized? Or been treated as a day case? If “yes” what for & when?		
Have you ever been treated for depression, anxiety, sleeping disorder, panic attacks or ever had a nervous breakdown?		
Have you ever been registered disabled or had disability allowance?		
Do you suffer from ulcers, rashes, itchy skin anywhere on your body or ever get cold sores??		
Have you ever had a bad reaction to a general Anaesthetic or sedation or had a bad reaction to an injection or any other adverse reaction while having dental treatment?		
Do you have arthritis or any other problems with your joints or have you ever been treated for Osteoporosis? If yes give details of any treatment/medication in the last 5 years.		
Have you ever been told you have a heart murmur, other heart problem, angina, high or low blood pressure, have had a heart attack, have a pacemaker, or have you had any form of heart or blood vessel surgery?		
Do you suffer from bronchitis, difficult breathing, snoring or other chest condition or suffer from any breathing or sleeping disorder (COPD or Sleep Apnea)		
Do you suffer from asthma? If yes give details of any asthma medication you have taken in the last 5 years; and if yes give details of the last attack and how many attacks in the last 12 months; and if yes give details of any subsequent hospital admission or visit to casualty		
Do you experience fainting attacks, giddiness, blackouts or epilepsy?		
Are you Diabetic? If yes what type of Diabetes and list your medication?		
Have you ever had a bleeding disorder, taken Warfarin or any other anticlotting agent, or do you bruise easily or bled excessively following a tooth extraction, surgery or injury?		
Do you consume alcohol, and if yes then indicate units per week?		
Have ever been a registered drug addict or treated for substance abuse? Or do you use or have used in previous 6 months, any illegal substances (Pot, Heroin, methadone etc)		

Are there any other aspects concerning your health that you think the dentist should know about? Medical histories help to identify problems that affect your dental health and the effectiveness of your dental care. If you answered yes to any questions e.g. any illness, medication or medical problem please give details below.

Completed by: patient/guardian Signature: Date // //